

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-009927

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 302

FILED MAR 19 1962

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY Buchanan	b. CITY (If outside corporate limits, give TOWNSHIP only) St. Joseph	a. STATE Missouri	b. COUNTY Buchanan
c. FULL NAME OF (If NOT in hospital, give location) Missouri Methodist Hosp.		d. STREET ADDRESS 1070 N. Noyes	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last RAYMOND ROSSE CALKINS		Month Day Year March 8, 1962	
5. SEX male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11/13/1876
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President		11. BIRTHPLACE (City and state or country) St. Joseph, Mo.	
13a. FATHER'S NAME Ripley Calkins		14. NAME OF HUSBAND OR WIFE Irene F. Calkins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes		17. INFORMANT Mrs. R. R. Calkins, 1070 N. Noyes	
18. CAUSE OF DEATH (Enter only one cause per line)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:		4 hours	
IMMEDIATE CAUSE (a) Cardiac decompensation			
DUE TO (b) A. S. H. D.		years.	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from 1948 to 1962 and last saw him alive on 8 March 1962 Death occurred at 6:05 p. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) William P. McDonald M.D.		22b. ADDRESS 301 N. 8th St. St. Joseph	22c. DATE SIGNED 12 March 62
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 3/10/1962	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) (State) St. Joseph Missouri
24. FUNERAL DIRECTOR Wesley Bowman		25. DATE RECD. BY LOCAL REG. Mar. 15, 1962	26. REGISTRAR'S SIGNATURE Thos. Clark Goodell

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF MEDICAL CERTIFICATION
W.P. McDONALD, M.D.

USE BLACK INK
OR
TYPEWRITER RIBBON

NOV 21 1962
KS APR 6 - 1962

MAY 3 1962

MAR 23 1962

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Eugene Wood

Licensed Embalmer No. 3804

P. O. Address 314 S. 10th, St. Joseph, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.